Novus Vita Health Ltd. Company Reg. No. ***11294130***

New Child Patient Questionnaire

Date:

ALL INFORMATION IS STRICTLY CONFIDENTIAL

Patients (Childs) Information:

Name:

Surname:

Male/Female:

Age:

Date of Birth:

Physical Address:

Postal Address: (if different from above)

Parent/Guardian's Personal Information:

Full name:

Email:

Mobile number:

Home number:

Work number:

Occupation:

Marriage status:

Child's Medical History:

Birth weight:

Complications during pregnancy(if any):

Natural Birth / Caesarian:

Complications during birth:

Duration and complications of breast feeding:

Has the child been vaccinated (immunized)? Yes / No (please circle)

If so, please list the vaccinations and any possible reactions experienced:

Family Medical History:

Please let me know if any of the following family members have suffered from any of the following:

Cancer, Heart disease, TB, Diabetes, Thyroid conditions, Sexually Transmitted Infections, Alzheimers Disease, Dementia, Multiple Sclerosis, Mental illness / handicap, Schizophrenia, Eczema, Psoriasis, Migraine, Epilepsy, Allergies, Asthma, Drug / Alcohol addiction, Arthritis, Anaemia or any other illness you may think significant.

(If deceased, please kindly indicate the age and cause of death if known.)

Mother

Father

Maternal Grandmother

Maternal Grandfather

Paternal Grandmother

Paternal Grandfather

Child's Siblings

Is there any other important information you may want to add?

Terms & Conditions for Novus Vita Health Ltd (trading as "Novus Vita"

- **I have answered all the above questions to the best of my knowledge and will undertake to inform Novus Vita of any alterations to the above as soon as possible in writing.**
- **I understand and I am fully aware that the advice and treatments recommended by Novus Vita are taken at my own discretion. I also understand that Novus Vita does not intend to diagnose any medical conditions and will assume no medical or legal liability of such kind.**
- **I understand that email correspondence is not a secure form of communication. Someone else could change the content or read the emails before they arrive. I will limit the extent to which personal or sensitive information is sent by me to Novus Vita by email**
- **I accept that any legal disputes arising in relation to the services provided by Novus Vita will be governed by English laws and is subject to the exclusive jurisdiction of the English courts.**
- **I am aware of and give consent to Novus Vita to use my case for education or research purposes, and I understand that my personal information will never be disclosed unless I have authorised so in writing.**
- **I understand my responsibility to settle all payments promptly and agree to the fee structure as laid out by Novus Vita.**
- **I accept that Novus Vita operates a 24hr cancellation policy. Patients and prospective patients are required to give 24 hours notification of cancellation in writing to drcahill@novusvita.co.uk failing which the full consultation fee shall be payable.**

Date:_____ **Parent (Guardian) Signature:_____**

Place:_____

Novus Vita Health Ltd.

Dr. Jodi Cahill M.Tech.Hom(SA), PGCE (DTTLS)

Homeopathic Doctor, Naturopathic Practitioner and Registered Homotoxicologist